FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037655

Facility Name: FAIRVIEW NURSING PLAZA INC.

Address: 321 ARNOLD AVE (Number) ROCKFORD (City) 61108 (Zip Code)

County: WINNEBAGO

Telephone Number: (815) 397-5531 **Fax #** (815) 397-7629

IDPA ID Number: 363782675001

Date of Initial License for Current Owners: 09/01/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3	114	Intermediate (ICF)	114	41,610	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,745	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,979	923	310	20,212	8
9	SNF/PED					9
10	ICF	44,285	2,154	424	46,863	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,264	3,077	734	67,075	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.28%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 310

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,424	27,943	34,932	243,299		243,299	(21,640)	221,659			1
2	Food Purchase		287,161		287,161	(17,119)	270,043	(131)	269,911			2
3	Housekeeping	175,875	22,373		198,248		198,248	719	198,967			3
4	Laundry	80,234	24,484		104,718		104,718		104,718			4
5	Heat and Other Utilities			121,178	121,178		121,178	2,222	123,400			5
6	Maintenance	44,440	15,719	76,980	137,139		137,139	(17,854)	119,285			6
7	Other (specify):*			5,680	5,680		5,680	3,326	9,006			7
8	**TOTAL General Services**	480,973	377,680	238,770	1,097,423	(17,119)	1,080,305	(33,358)	1,046,946			8
	B. Health Care and Programs											
9	Medical Director			7,300	7,300		7,300		7,300			9
10	Nursing and Medical Records	1,452,617	92,456	491,087	2,036,160		2,036,160	(28,369)	2,007,791			10
10a	Therapy	39,701		9,247	48,948		48,948		48,948			10a
11	Activities	101,027	12,490	2,304	115,821		115,821		115,821			11
12	Social Services	135,079		5,387	140,466		140,466		140,466			12
13	Nurse Aide Training											13
14	Program Transportation			757	757		757		757			14
15	Other (specify):*							3,728	3,728			15
16	**TOTAL Health Care and Programs**	1,728,424	104,946	516,082	2,349,452		2,349,452	(24,641)	2,324,811			16
	C. General Administration											
17	Administrative	106,814		79,056	185,870		185,870	22,393	208,263			17
18	Directors Fees											18
19	Professional Services			174,102	174,102		174,102	(96,382)	77,720			19
20	Dues, Fees, Subscriptions & Promotions			36,310	36,310		36,310	(11,764)	24,546			20
21	Clerical & General Office Expenses	95,413		83,329	178,742		178,742	36,040	214,782			21
22	Employee Benefits & Payroll Taxes			289,274	289,274	17,119	306,393	(3,640)	302,753			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,409	2,409		2,409	32	2,441			24
25	Other Admin. Staff Transportation			1,516	1,516		1,516	3,866	5,382			25
26	Insurance-Prop.Liab.Malpractice			71,646	71,646		71,646	1,159	72,805			26
27	Other (specify):*							31,131	31,131			27
28	**TOTAL General Administration**	202,227		737,642	939,869	17,119	956,988	(17,165)	939,823			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,411,624	482,626	1,492,494	4,386,744		4,386,744	(75,164)	4,311,580			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. #0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			60,344	60,344		60,344	4,854	65,198			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,706	76,706		76,706	3,096	79,802			32
33	Real Estate Taxes			100,025	100,025		100,025	4,695	104,720			33
34	Rent-Facility & Grounds			855,195	855,195		855,195		855,195			34
35	Rent-Equipment & Vehicles			9,633	9,633		9,633	7,994	17,627			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,101,903	1,101,903		1,101,903	20,639	1,122,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,178	14,142	49,320		49,320	(5,000)	44,320			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,617	116,617		116,617		116,617			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		35,178	130,759	165,937		165,937	(5,000)	160,937			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,411,624	517,804	2,725,156	5,654,584		5,654,584	(59,525)	5,595,059			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,768)	30		9
10	Interest and Other Investment Income	(1,774)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(131)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,213)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,926)	21		24
25	Fund Raising, Advertising and Promotional	(3,828)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,296)	20		28
29	Other-Attach Schedule	(35,862)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,798)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	10,273		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 10,273		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (59,525)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIRVIEW NURSING PLAZA INC.

ID# 0037655

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (5,869)	6	1
2	COPE - IL Council	(3,743)	20	2
3	Trust Fees	(200)	20	3
4	Veteran's Expenses	(6,209)	10	4
5	Prior year pharmacy expenses	(5,000)	39	5
6	Court fees	(181)	19	6
7	Out of period seminar	(380)	24	7
8	Non-allowable legal fees	(9,883)	19	8
9	Non-allowable employee benefits	(3,640)	22	9
10	Non-allowable travel	(757)	20	10
11				11
12				12
13				13
14				14
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(21,640)							(21,640)	1
2	Food Purchase	(131)											(131)	2
3	Housekeeping			719									719	3
4	Laundry													4
5	Heat and Other Utilities			867	1,355								2,222	5
6	Maintenance	(5,869)		643	(12,529)	(99)							(17,854)	6
7	Other (specify):*				735	2,591							3,326	7
8	**TOTAL General Services**	(6,000)		2,229	(10,439)	(19,148)							(33,358)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,209)			(22,160)								(28,369)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,728								3,728	15
16	**TOTAL Health Care and Programs**	(6,209)			(18,432)								(24,641)	16
	C. General Administration													
17	Administrative			16,561	(66,471)	67,892		4,411					22,393	17
18	Directors Fees													18
19	Professional Services	(10,064)		(90,136)	(10,001)	13,800		19					(96,382)	19
20	Fees, Subscriptions & Promotions	(12,037)		84	177			12					(11,764)	20
21	Clerical & General Office Expenses	(22,926)		52,535	6,413			18					36,040	21
22	Employee Benefits & Payroll Taxes	(3,640)											(3,640)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(380)		121	291								32	24
25	Other Admin. Staff Transportation			680	3,186								3,866	25
26	Insurance-Prop.Liab.Malpractice			448	674			37					1,159	26
27	Other (specify):*			9,585	8,719	12,312		515					31,131	27
28	**TOTAL General Administration**	(49,047)		(10,122)	(57,012)	94,004		5,012					(17,165)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,256)		(7,893)	(85,883)	74,856		5,012					(75,164)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,768)		2,662	3,960								4,854	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,774)		1,181	3,689								3,096	32
33	Real Estate Taxes			1,620	3,075								4,695	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			2,756	4,946			292					7,994	35
36	Other (specify):*													36
37	TOTAL Ownership	(3,542)		8,219	15,670			292					20,639	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(5,000)											(5,000)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(5,000)											(5,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,798)		326	(70,213)	74,856		5,304					(59,525)	45

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 719	$ 719	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	867	867	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	643	643	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,561	16,561	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,882	1,882	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	84	84	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	52,535	52,535	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	121	121	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	680	680	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	448	448	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,585	9,585	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,662	2,662	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,181	1,181	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,620	1,620	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,756	2,756	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	92,018	PREFERRED BOOKKEEPING	100.00%		(92,018)	32
33	V	19	COMPUTER	5,112	PREFERRED BOOKKEEPING	100.00%	5,112		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 97,130			$ 97,456	$ * 326	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,355	$ 1,355	15
16	V	6	REPAIRS AND MAINT.	19,176	S.I.R. MANAGEMENT, INC.	100.00%	6,647	(12,529)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	735	735	17
18	V	10	NURSING	42,180	S.I.R. MANAGEMENT, INC.	100.00%	20,020	(22,160)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,728	3,728	19
20	V	17	ADMINISTRATIVE	74,736	S.I.R. MANAGEMENT, INC.	100.00%	8,265	(66,471)	20
21	V	19	PROFESSIONAL FEES	17,256	S.I.R. MANAGEMENT, INC.	100.00%	7,255	(10,001)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	177	177	22
23	V	21	CLERICAL & GENERAL	21,732	S.I.R. MANAGEMENT, INC.	100.00%	28,145	6,413	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	291	291	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,186	3,186	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	674	674	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,719	8,719	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,960	3,960	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,689	3,689	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,075	3,075	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,946	4,946	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 175,080			$ 104,867	$ * (70,213)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 21,732	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,852	$ (15,880)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,101	1,101	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	67,892	67,892	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,800	13,800	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,312	12,312	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	288	S.I.R. MANAGEMENT, INC.	100.00%	189	(99)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	37	37	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	7,440	(5,760)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,453	1,453	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 35,220			$ 110,076	$ * 74,856	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 59,672	$ 59,672	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	59,672	CCS EMPLOYEE BENEFIT GROUP	100.00%		(59,672)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 59,672			$ 59,672	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 19	$ 19	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12	12	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	18	18	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	37	37	18
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	292	292	19
20	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%		(4,320)	20
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	8,731	8,731	21
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	515	515	22
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,320			$ 9,624	$ * 5,304	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Owner	Administrative	27.78%	See Attached	4.27	9.49%	alloc sal	$ 17,835	17-7	1
2	Louise Bergthold	Owner	Administrative	2.63%	See Attached	5.88	10.69%	alloc sal	19,714	17-7	2
3	Mike Giannini	Owner	Administrative	31.67%	See Attached	4.27	9.49%	alloc sal	17,956	17-7	3
4	Tom Winter	Owner	Administrative	0.88%	See Attached	6.39	10.65%	alloc sal	16,561	17-7	4
5	Arturo Rominiquit	Relative	Courier	0%	See Attached	4.26	10.65%	alloc sal	2,413	21-7	5
6	Nenita Guzman	Relative	Dietary	0%	See Attached	5.34	10.68%	alloc sal	5,852	1-7	6
7	Mark Solomon	Owner	Administrator	6.58%	None	40	100.00%	salary	85,813	17-1	7
8	Eric Rothner	Relative	Administrative		See Attached	.67	0.93%	alloc sal	1,645	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 167,789		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	863,792	11	$ 6,745	$	92,018	$ 719	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	863,792	11	8,137		92,018	867	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	863,792	11	6,035		92,018	643	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	863,792	11	155,464	155,464	92,018	16,561	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	863,792	11	17,663		92,018	1,882	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	863,792	11	788		92,018	84	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	863,792	11	493,157	432,172	92,018	52,535	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	863,792	11	1,135		92,018	121	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	863,792	11	6,379		92,018	680	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	863,792	11	4,205		92,018	448	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	863,792	11	89,973		92,018	9,585	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	863,792	11	24,993		92,018	2,662	12
13	32	INTEREST	BOOK./ACCNT.INCOME	863,792	11	11,085		92,018	1,181	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	863,792	11	15,206		92,018	1,620	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	863,792	11	25,868		92,018	2,756	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,112	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,833	$ 587,636		$ 97,456	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	$ 12,680	$	67,253	$ 1,355	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	67,253	6,647	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		67,253	735	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	67,253	20,020	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		67,253	3,728	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	67,253	8,265	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		67,253	7,255	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		67,253	177	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	67,253	28,145	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		67,253	291	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	629,428	10	29,820		67,253	3,186	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		67,253	674	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		67,253	8,719	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		67,253	3,960	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		67,253	3,689	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		67,253	3,075	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		67,253	4,946	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 981,450	$ 522,555		$ 104,867	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	$ 54,767	$ 54,767	67,253	$ 5,852	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		67,253	1,101	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	629,428	10	635,411	635,411	67,253	67,892	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	629,428	10	129,159		67,253	13,800	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	629,428	10	$ 115,229	$	67,253	$ 12,312	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 11,413	$		$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	288	189	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	$ 28,377	$	288	$ 37	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	70,679	70,679	13,200	7,440	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	13,799		13,200	1,453	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,272,944	$ 964,662		$ 110,076	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 59,672	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 59,672	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 430	$	4,320	$ 19	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	400		4,320	18	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	813		4,320	37	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,493		4,320	292	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	96,000	9			4,320		6
7	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	79,839	79,839	4	8,731	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		4	515	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,413	$ 79,839		$ 9,624	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Insurance		X	working capital	$130						1,039	6
7	SIR Management	X		Line of Credit				1,445,000			75,667	7
8												8
9	TOTAL Facility Related				$130		$	$ 1,445,000			$ 76,706	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										3,096	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,096	14
15	TOTALS (line 9+line14)						$	$ 1,445,000			$ 79,802	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (1,774)	1
2	Allocation - Preferred Bkkpg	X									1,181	2
3	Allocation - SIR Mgmt	X									3,689	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 3,096	21

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	105,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	105,920	2
3. Under or (over) accrual (line 2 minus line 1).	$	320	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	104,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	104,720	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	100,425	8
	1997	102,255	9
	1998	103,278	10
	1999	102,486	11
	2000	101,225	12

2001 accrual = actual tax X 3% (101,225 X1.03) = 104,262 (rounded to 104,400)

Real Estate Tax expense include allocations from related parties:
Preferred Mgmt: $1,620; SIR Mgmt: $3,075

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRVIEW NURSING PLAZA INC. COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-28-203-004	Long Term Care Property	$ 101,225.44	$ 101,225.44
2.	SEE ATTACHED	SIR MGMT ALLOCATION	$ 64,023.09	$ 4,828.65
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 165,248.53	$ 106,054.09

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,808 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	55,434		20	2,772	2,772	26,545	9
10	Various			1993	68,424		20	3,421	3,421	28,610	10
11	Various			1994	44,837		20	2,242	2,242	17,608	11
12	Various			1995	14,482		20	724	(724)	4,401	12
13	Various			1996	7,472		20	374	374	2,065	13
14	Various			1997	73,164		20	3,658	3,658	16,942	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		87,637	3,243		3,455	212	22,632	68
69	Financial Statement Depreciation			24,890			(24,890)		69
70	TOTAL (lines 4 thru 69)		$ 351,450	$ 28,133		$ 16,646	$ (12,935)	$ 118,803	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 351,450	$ 28,133		$ 16,646	$ (11,487)	$ 118,803	1
2	SMOKE DETECTORS	1998	3,145		20	157	157	602	2
3	ELECTRICAL WORK	1998	5,825		20	291	291	1,043	3
4	MINI BLINDS	1998	769		20	38	38	76	4
5	MINI BLINDS	1998	7,568		20	378	378	756	5
6	EVAPORATOR	1998	1,680		20	84	84	168	6
7	ELEVATOR REPAIR	1999	8,463		20	423	423	1,234	7
8	COUNTER TOPS	1999	4,880		20	488	488	1,911	8
9	HVAC-HEAT EXCHANGES	1999	4,000		20	200	200	600	9
10	HVAC-HEAT EXCHANGER	1999	4,100		20	205	205	547	10
11	WATER HEATER	1999	8,709		20	435	435	1,088	11
12	ELEVATOR WORK	1999	4,002		20	200	200	483	12
13	SIR REMODELING	1999	11,917		20	596	596	1,341	13
14	ELEVATOR WORK	1999	2,962		20	148	148	345	14
15	HVAC EXCHANGER	1999	3,875		20	194	194	420	15
16	ROOM DIVIDERS	1999	6,841		20	342	342	741	16
17	HVAC EXCHANGER	1999	3,731		20	187	187	405	17
18	WATER SOFTNER	1999	2,000		20	200	200	1,017	18
19	WATER HEATER	2000	4,598		20	230	230	441	19
20	HEAT EXCHANGER	2000	1,145		20	57	57	109	20
21	PAINTING	2000	16,100		20	805	805	1,073	21
22	HANDRAILS	2000	8,261		20	413	413	688	22
23	WINDOW TREATMENT	2000	2,904		20	145	145	242	23
24	PAINTING	2000	10,000		20	500	500	542	24
25	HEAT EXCHANGER	2000	3,940		20	197	197	213	25
26	PAINTING	2001	4,000		20	200	200	200	26
27	PAINTING	2001	7,000		20	321	321	321	27
28	ELEVATOR WORK	2001	11,945		20	547	547	547	28
29	HVAC WORK	2001	4,148		20	121	121	121	29
30	PATIO LIGHT	2001	1,302		20	33	33	33	30
31	WATER HEATER	2001	9,438		20	118	118	118	31
32	CARPETING	2001	3,845		20	32	32	32	32
33	FREEZER COMPRESSOR	2001	2,101		20	105	105	105	33
34	TOTAL (lines 1 thru 33)		$ 526,644	$ 28,133		$ 25,036	$ (3,097)	$ 136,365	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 526,644	$ 28,133		$ 25,036	$ (3,097)	$ 136,365	1
2	FREEZER WORK	2001	1,561		20	65	65	65	2
3	HEATER REPAIR	2001	2,207		20	9	9	9	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 530,412	$ 28,133		$ 25,110	$ (3,023)	$ 136,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR PRP-PB		1993		$ 15,042	$ 478	35	$ 430	$ (48)	$ 3,653	4
5	SIR PRP-SM		1993		28,551	906	35	816	(90)	6,934	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION - SIR PROPERTIES-PREFFERED BKKPG		1999		1,906	191	20	95	(96)	238	9
10	ALLOCATION - SIR PROPERTIES-PREFFERED BKKPG		1998		911	91	20	46	(45)	159	10
11	ALLOCATION - SIR PROPERTIES-PREFFERED BKKPG		1997		57	6	20	3	(3)	16	11
12	ALLOCATION - SIR PROPERTIES-PREFFERED BKKPG		1994		143	4	20	7	(3)	54	12
13	ALLOCATION - SIR PROPERTIES-PREFFERED BKKPG		1993		244	7	20	12	5	104	13
14	ALLOCATION -PREFFERED BKKPG		1997		18,786	421	20	939	518	4,517	14
15	ALLOCATION -PREFFERED BKKPG		1999		149	29	20	7	(22)	19	15
16	ALLOCATION -PREFFERED BKKPG		2000		942		20	47	47	67	16
17	ALLOCATION - SIR PROPERTIES-SIR MGMT		1999		3,618	362	20	181	(181)	452	17
18	ALLOCATION - SIR PROPERTIES-SIR MGMT		1998		1,729	173	20	86	(87)	303	18
19	ALLOCATION - SIR PROPERTIES-SIR MGMT		1997		108	11	20	5	(6)	30	19
20	ALLOCATION - SIR PROPERTIES-SIR MGMT		1994		272	7	20	14	7	104	20
21	ALLOCATION - SIR PROPERTIES-SIR MGMT		1993		463	13	20	23	10	197	21
22	ALLOCATION-SIR MANAGEMENT		1993		12,262	341	20	619	278	5,452	22
23	ALLOCATION-SIR MANAGEMENT		1994		38		20	4	4	28	23
24	ALLOCATION-SIR MANAGEMENT		1995		280		20	14	14	90	24
25	ALLOCATION-SIR MANAGEMENT		1999		1,332	63	20	67	4	147	25
26	ALLOCATION-SIR MANAGEMENT		2000		804	140	20	40	(100)	68	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 87,637	$ 3,243		$ 3,455	$ 206	$ 22,632	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 415,048	$ 37,129	$ 39,799	$ 2,670	10	$ 255,652	71
72	Current Year Purchases	10,139	1,215	291	(924)	10	291	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 425,187	$ 38,344	$ 40,090	$ 1,746		$ 255,943	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY BUSINESS	CHEVY VAN	1996	$ 11,516	$ 491	$	$ (491)	5	$ 11,516	76
77										77
78										78
79										79
80	TOTALS			$ 11,516	$ 491	$	$ (491)		$ 11,516	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 967,115	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,968	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,200	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,768)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 403,898	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FIRST CHICAGO TRUST COMPANY OF ILLINOIS

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		213		$ 855,195			3
4	Additions							4
5								5
6								6
7	TOTAL		213		$ 855,195 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 02/1996
Ending 09/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 17,335 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from ECM Owner's Council		$	$ 292	17
18					18
19					19
20					20
21	TOTAL		$	$ 292	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 6,820	$		$ 6,820	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			482			482	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			6,840			6,840	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				16,350		16,350	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						18,828		18,828	13
14	TOTAL			$		$ 14,142	$ 35,178		$ 49,320	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,574	$	1
2	Cash-Patient Deposits	38,286		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,239,386		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,023		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	98,139		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,409,408	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	234,809		15
16	Equipment, at Historical Cost	486,572		16
17	Accumulated Depreciation (book methods)	(442,654)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	5,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 283,727	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,693,135	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 177,698	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,898		28
29	Short-Term Notes Payable	1,445,000		29
30	Accrued Salaries Payable	187,089		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,057		31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,400		32
33	Accrued Interest Payable	1,633		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	107,445		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,080,220	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,080,220	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (387,085)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,693,135	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (279,444)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (279,444)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(107,641)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (107,641)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (387,085)	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,515,496	1
2	Discounts and Allowances for all Levels	(42,261)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,473,235	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	36,617	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 36,617	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,870	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,519	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,515	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,904	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,774	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,774	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	14,413	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,413	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,546,943	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,097,423	31
32	Health Care	2,349,452	32
33	General Administration	939,869	33
	B. Capital Expense		
34	Ownership	1,101,903	34
	C. Ancillary Expense		
35	Special Cost Centers	49,320	35
36	Provider Participation Fee	116,617	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,654,584	40
41	**Income before Income Taxes (line 30 minus line 40)****	(107,641)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (107,641)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,843	2,001	$ 63,383	$ 31.68	1
2	Assistant Director of Nursing	2,875	3,077	68,360	22.22	2
3	Registered Nurses	1,499	1,579	31,402	19.89	3
4	Licensed Practical Nurses	27,679	30,466	519,888	17.06	4
5	Nurse Aides & Orderlies	65,750	69,720	723,583	10.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,607	3,824	39,701	10.38	8
9	Activity Director	1,810	1,883	22,005	11.69	9
10	Activity Assistants	10,806	11,464	79,022	6.89	10
11	Social Service Workers	12,951	13,970	135,079	9.67	11
12	Dietician					12
13	Food Service Supervisor	3,349	3,582	42,452	11.85	13
14	Head Cook	3,053	3,237	23,277	7.19	14
15	Cook Helpers/Assistants	17,366	18,159	114,695	6.32	15
16	Dishwashers					16
17	Maintenance Workers	3,739	3,980	44,440	11.17	17
18	Housekeepers	22,654	24,038	175,875	7.32	18
19	Laundry	9,842	10,464	80,234	7.67	19
20	Administrator	1,910	2,086	85,813	41.14	20
21	Assistant Administrator	595	946	21,001	22.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,276	9,855	95,413	9.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,765	4,058	46,001	11.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,369	218,389	$ 2,411,624 *	$ 11.04	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	$ 13,200	01-03	35
36	Medical Director	monthly	7,300	09-03	36
37	Medical Records Consultant	98	3,445	10-03	37
38	Nurse Consultant	monthly	42,180	10-03	38
39	Pharmacist Consultant	59	1,175	10-03	39
40	Physical Therapy Consultant	152	7,600	10a-03	40
41	Occupational Therapy Consultant	32	1,597	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	50	10a-03	43
44	Activity Consultant	50	2,304	11-03	44
45	Social Service Consultant	102	5,387	12-03	45
46	Other(specify)				46
47	Director of Food Service	543	21,732	01-03	47
48					48
49	TOTAL (lines 35 - 48)	1,037	$ 105,970		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,156	$ 159,841	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	15,933	284,446	10-03	52
53	TOTAL (lines 50 - 52)	21,089	$ 444,287		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Solomon	Administrator	7%	$ 85,813
Lori Fernando (1/01-4/01)	Asst. Admin	0	21,001
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,814

B. Administrative - Other

Description	Amount
Director of Administrative Services	$ 26,844
Ancillary Administrative Charges	47,892
ECM Owners Council Dues	4,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 79,056
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Preferred Bookkeeping	Accounting	$ 20,450
Frost, Ruttenberg & Rothblatt	Accounting	20,628
Personnel Planners	Unemployment Consult	2,255
Preferred Bookkeeping	Computer Services	5,112
Mid America Programming	Computer Services	1,320
Stuart Sikes	Court Fees - adj. out pg 5	181
Sinclair Kossoff	Union Arbitration fee	906
ICS	Computer Services	80
See attached	Legal	34,346
Preferred Bookkeeping	Bookkeeping	71,568
SIR Mgmt	Regulatory Consulting	17,256
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 174,102

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,939
Unemployment Compensation Insurance	30,821
FICA Taxes	182,677
Employee Health Insurance	41,976
Employee Meals	17,119
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	11,381
401K Matching	1,840
TOTAL (agree to Schedule V, line 22, col.8)	$ 302,753

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	17,669
Health Care Worker Background Check	
(Indicate # of checks performed 140)	983
Yellow Page Ads	2,296
Dues & Subscriptions & Licenses	5,421
Advertising & Promotion	3,828
Allocation Preferred Bkkpg	84
Allocation SIR Mgmt	177
Allocation ECM Owner's Council	12
Less: Public Relations Expense	
Non-allowable advertising	(3,828)
Yellow page advertising	(2,296)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,546

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,029
Allocation Preferred Bkkpg	121
Allocation SIR Mgmt	291
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,441

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Council LTC $8,257

(3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,849 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 116,617
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 17,119 Has any meal income been offset against related costs? n/a Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of In
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees